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8 9	BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS		
10	In the Matter of the Accusation Against:	Case No. 2013 - 248	
12	GRACE MADARANG TATLONGHARI		
13	23024 Atmore Avenue Carson, CA 90745	ACCUSATION	
14	Registered Nurse License No. 657140		
15	Respondent.		
16	Complainant alleges:	-	
17	PAR	<u>eties</u>	
18	1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her		
19	official capacity as the Executive Officer of the Board of Registered Nursing (Board),		
20	Department of Consumer Affairs.		
21	2. On or about May 3, 2005, the Board issued Registered Nurse License Number		
22	657140 to Grace Madarang Tatlonghari (Respondent). The Registered Nurse License was in fu		
23	force and effect at all times relevant to the charg	es brought herein and will expire on December	
24	31, 2012, unless renewed.		
25	<u>JURISDICTION</u>		
26	3. This Accusation is brought before the Board under the authority of the following		
27	laws. All section references are to the Business and Professions Code (Code) unless otherwise		
28	indicated.		
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STATUTORY PROVISIONS

- 4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.
 - 6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- "(a) Unprofessional conduct, which includes, but is not limited to, the following:
- "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

REGULATORY PROVISION

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY PROVISION

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. This does not preclude the Board from including cost recovery in a stipulated settlement.

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PATIENT BV

- 9. On or about January 21, 2007, at about 1300 hours, 67 year-old Patient BV was admitted to the Emergency Department (ED) at the Southern California Permanente Medical Group (SCPMG) with chills and weakness. Patient BV had a history of diabetes, hypertension, coronary artery disease, end-stage renal disease on dialysis and peripheral vascular disease. While in the ED, a triple lumen catheter was inserted in his right femoral artery. At 1323 hours, lab results show that Patient BV's hemoglobin level was 11.1. The ED physician orders state that Patient BV's platelet count was to be kept above 50,000. The patient was receiving multiple anticoagulant medications including Heparin and Integrilin drip, as well as Plavix and Aspirin. There was no mention of bleeding from the catheter site in the ED notes.
- 10. At 2130 hours, Patient BV was transferred to SCPMG's Step Down Unit where Respondent was working as a registered nurse and assigned to care for Patient BV. Respondent documented in the Adult Initial Assessment form at 2130 hours that Patient BV was "awake, A/O x4 ... pt denies chest pain ... Heparin & Integrilin infusing into R wrist IV access..." She also described the triple lumen catheter on the right groin as showing a "small amount of blood".
- 11. At 2300 hours, Respondent documented in the Multidisciplinary Progress Notes that she noted the patient to have "large amount of blood oozing from the central site (R groin)...IOD (Dr. Zukotynski) notified. Ordered to place pressure dressing over central line site. Bleeding decreased. Will continue to monitor closely."
 - 12. At 2315 hours, lab results show that Patient BV's hemoglobin level was 9.4.
- 13. At 0030 hours on January 22, 2007, Respondent documented: "Pt sleeping but easily arousable...Rx notified & ordered to [decrease] Heparin...oozing of blood from central line site continued. IOD (Dr. Zukotynski) notified and ordered to keep pressure on the bleeding site...IOD made aware of drop from 11.0 Hgb [hemoglobin] to 9.4. Will continue to monitor."
 - 14. At 0210 hours, a physician ordered "decrease Heparin drip..."
 - 15. At 0210 hours, lab results show that Patient BV's hemoglobin level was 9.0.
- 16. At 0400 hours, Respondent documented: "Pt is sleeping but easily arousable...BP currently 99/54, HR 71, 100% O2 sat...A central line site continues to bleed when pressure is

released Pt Hgb now 9.0. IOD (Dr. Zukotynski) notified [with] order to hold/stop Integrilin or
HeparinIOD notified about [decrease] in Hgbcall IOD if Hgb is below 9.0. Will continue
monitor pt."

- 17. At 0415, Dr. Zukotynski documented: "IOD called for bleeding at femoral vein catheter site. At this time Integrilin and Heparin will be d/c. Hgb/Hct will be rechecked." Dr. Zukotynski ordered "Repeat Hgb/Hct in one hour. Page MD [with] results. Type and Screen 2 units of PRBC. Hold Integrilin and heparin."
- 18. At 0530 hours, Respondent documented: "Pt sleeping, slow to arouse but able to state name, place...Pt noted to have hematoma on R groin. IOD notified (Dr. Cheung) & stated she will come and assess the pt. Will continue to monitor pt closely."
- 19. At 0544 hours, Respondent documented: "Pt now non-responsive even to painful stimuli...B/P: 59/23, HR: 106. IOD notified [with] new orders, given & carried out. IOD (Dr. Cheung) on the floor assessing pt will monitor closely."
- 20. At 0600 hours, Dr. Cheung documented: "IOD called for ALOC...Integrilin/Hep D/C'd 4 am for femoral cath site hemotoma. Pt obtunded....Extr large hemotoma R groin..."
- 21. At 0620 hours, Respondent documented: "Pt still non-responsive. B/P: 51/29, HR:106. Pt given NS [normal saline] 1000 ml bolus. TLC [triple lumen catheter] inserted into L femoral inserted by Dr. Fane. Will monitor pt."
- 22. At 0622 hours, Respondent documented: "...unable to take pt's B/P. Dopamine drip started at 5mcg/kg/min. Dr. Cheung at the bedside."
- 23. At 0624 hours, Respondent documented: "Pt still [with] no B/P, still unresponsive. Code Blue called."
 - 24. At 0626 hours, Patient BV expired.
 - 25. At 0650 hours, lab results show that Patient BV's hemoglobin level was 5.6.
 - 26. The Certificate of Death lists as Cause of Death the following:

Acute Myocardial Infarction Hematoma Bleed from Anticoagulant End Stage Renal Disease

CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

- 27. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, in that on January 21-22, 2007, Respondent was grossly negligent in her care of Patient BV. The circumstances are as alleged in paragraphs 9-26 which are incorporated herein by reference, and as follows:
- a. Respondent failed to provide continuous monitoring of Patient BV. Respondent failed to initiate more frequent records of the patient's vital signs and the condition of the bleeding site, and to provide pressure on the bleeding site. There were no nursing notes recorded from 0030 hours to 0400 hours on January 22, 2007.
- b. Respondent failed to immediately intervene to protect the safety of her patient or to notify her supervisor of the patient's condition. Although Respondent documented she notified of the physician of Patient BV's situation, the physician did not discontinue Integrilin and Heparin until 0400 hours on January 22, 2007.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

- 1. Revoking or suspending Registered Nurse License Number 657140, issued to Grace Madarang Tatlonghari;
- 2. Ordering Grace Madarang Tatlonghari to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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1	3. Taking such other and further action as deemed necessary and proper.	
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4	DATED: OCTOBER 09, 2012 ALOUISE R. BAILEY, M.ED., RN	
5	Executive Officer Board of Registered Nursing	
6	Department of Consumer Affairs State of California	
7	Complainant LA2012507264	
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Accusation